before 31 December 1975, so impairing the consultants' superannuation benefits compared with those available to our younger medical and technical colleagues as of right.

BRYAN ROSS
and 16 other consultants

Royal Hospital,
Sheffield

** The Secretary writes: "The Compensation and Superannuation Committee has already made representations to the DHSS on the lines suggested by Dr Ross and his colleagues."—ED, *BMJ*.

Non-GP clinical assistants and the hospital practitioner grade

SIR,—As clinical assistants who are not general practitioners we are members of a small group of doctors in the hospital service who lack organised representation. Most doctors in our position are married women who for various reasons do not wish to take whole-time appointments but who often possess specialist qualifications and experience. Hitherto we have enjoyed the same terms and conditions of service as our GP clinical assistant colleagues. However, the latter are now eligible for transfer to the hospital practitioner grade, which carries an enhanced salary scale. Because entry to the new grade is restricted to GPs we shall in future be receiving a substantially lower salary than GPs who are engaged on comparable duties to ourselves. This is both anomalous and unjust. The implication that clinical assistants who are GPs automatically merit a higher salary than those who are not is one which we find grossly offensive. It is a fact that many doctors in our situation are more highly qualified and experienced than GP colleagues and this is particularly so in our own specialty of anaesthetics.

We appreciate that the hospital practitioner grade was specifically designed to attract GPs into part-time work in the hospital service. It would, however, fulfil this purpose no less well if the grade were also open to doctors who are not GPs. What is required is a simple amendment to the regulations so as to allow doctors other than GPs to enter the hospital practitioner grade. We urge that the BMA should reopen negotiations with the Department of Health in order to secure this limited objective.

There can be no doubt that the interests of non-GP clinical assistants have been overlooked and we feel most strongly that the BMA should spare no effort to put right the injustice that has been permitted, albeit unwittingly, by our representatives. We are asking every doctor who shares our view to bring pressure to bear on the BMA and the Department of Health without delay.

ALISON M BENNETT
N CHATTERJEE
ALISON DUFF
ANNE LYTHGOE
PATRICIA M SIMPSON

Department of Anaesthetics,
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Salaries of medical assistants

SIR,—I notice that the salary scale of the hospital practitioner grade as published in your list of appointments starts at £610 for each weekly notional half day and rises by six increments to its maximum of £826. This latter is equivalent to a whole-time salary of £9086 annually. Once more the unfortunate medical assistant loses out. His maximum is of £7812, achieved after 14 increments, showing a difference of £1274.

At a time when the unity of the profession is more important than ever and when junior doctors are rightly protesting at being exploited, can we have an assurance that this anomaly will be pressed by our negotiators when the next Review Body round is due? As I have indicated before (18 January, p 156), many so graded are approaching retirement and depend on the maximum available for an adequate pension.

I M LIBRACH

Chadwell Heath Hospital,
Romford, Essex

Points from Letters

Mao's China

Dr P E BROWN (Gravesend, Kent) writes: The statement that modern-day China is ruled by a "pitiless dictator" whose genius is on a par with Hitler and Stalin (1 November, p 283) should not be allowed to go unchallenged. While I admit that some superficial likeness might be apparent if one concentrated wholly upon the material achievements of their respective régimes, I am certain that when a careful comparison of the quality of the life of ordinary people comes to be considered we will find no similarity whatever between the subjects of Hitler and Stalin and those of Mao's China. . . . It is not true that "everybody in China obeys"; on the contrary, the people tend to discuss their problems very openly and they usually reach a compromise. . . . They are very aware of what is happening in their own country; they are in fact somewhat disinterested in the affairs of other societies. The claim that they have abolished the "original sin" of acquisitiveness is not as extravagant as it would sound. A three-week visit to the Chinese mainland . . . may appear to be a very short time to anyone who has never been there. It is, however, a most remarkable experience and even this short glimpse is worth a lifetime of reading other people's reports. I admit I have not been in China over the Christmas season, but I have had the opportunity to take Holy Communion on Easter Sunday morning in a tiny Chinese chapel in the centre of Peking from a Chinese priest in the company of a very small Chinese congregation. The régime does not find any need, it would appear, to repress Christianity. Before the coming of Mao Tse Tung there were very few Chinese who had ever tasted "freedom"; they certainly had no freedom from poverty, famine, sickness, drug addiction, prostitution, or venereal disease. I agree that the price of freedom is a costly one and from the experience I have gained from my own visits to China every man and woman in that great country is prepared to work for it under a very inspired leadership.

Disposal of disposable syringes

Dr S W V DAVIES (Harrold, Beds) writes: Dustmen complain that they are at risk to injury from the needles of discarded disposable syringes. The following procedure will obviate this risk. After the needle has been fractured to comply with police requests, it is inserted, butt first, into the barrel of the syringe and the plunger pushed in after it. This secures it in a safe place where it can no longer risk the health of the dustman.

Baby battering and mental retardation

Dr A KUSHLICK and Mr J PALMER (Health Care Evaluation Research Team, Dawn House, Sleepers Hill, Winchester) writes: In his paper (3 May, p 262) and his joint monograph[1] Dr J E Oliver has called attention to the problem of child battering in general and as an important but unrecognised cause of severe mental retardation. . . . However infrequent such cases are, they are certainly tragic and there is a need for sensitive, effective intervention before the damage has been done. Looking for subhyaloid haemorrhages in the children of "abusive parents" is likely to lead only to detection of brain damage after it has occurred.

The evidence of the great stress which the demands of babies in their first year of life place on parents, especially if the parents are young, short of money, have older children, and have poor quality housing which may also be overcrowded[2,3] suggests that in such circumstances the "importunacy" of the baby may well become the last straw. It is essential that parents in this situation should be able to get practical assistance from professional workers who listen to their problems, avoid reacting punitively, and refer them to the colleague, in whatever profession, who is most appropriate to find a solution to their difficulties. Dr Oliver's case 3 might well be a tragic story of a mother who in eight weeks of persistence failed to get a specialist to notice that she and her husband had real problems. The only information provided concerns the physical state of the baby. We would be interested to hear of papers on "child abuse" which describe in systematic detail the methods used by the parents to cope with their children in the day-to-day environment. We would be particularly interested to hear of any papers which describe systematically any attempts to change these practices in the actual situation.

1 Oliver, J E, *et al*, *Severely Ill-treated Young Children in North-east Wiltshire*. Research Report No 4, Oxford University Department of Clinical Epidemiology, 1974.
2 Smith, S M, Hanson, R, and Noble, S, *British Journal of Psychiatry*, 1973, **125**, 568.
3 Smith, S M, Hanson, R, and Noble, S, *British Medical Journal*, 1973, **4**, 388.

Drug interactions with oral contraceptives

Dr JILL DOSSETOR (Newmarket, Suffolk) writes: There is well-documented informa-

tion on drug interactions with oral contraceptives, particularly when drugs like the barbiturates, rifampicin, phenylbutazone, or phenytoin induce the formation of hepatic microsomal enzymes. With enzyme-inducing drugs the activity of oral contraceptives is reduced and breakthrough bleeding not uncommon, and pregnancy has been attributed to this interaction mechanism. I have now seen three cases in which patients on oral contraceptive drugs have become pregnant when given ampicillin and wonder if others have had similar experiences. . . . I believe we should be giving more serious thought to drug interaction and oral contraception. A patient for whom a new drug is being prescribed should always be asked if she is taking oral contraceptives in order that we may prevent further unwanted pregnancies or the need for a termination in a girl who is already sick.

Waiting lists for outpatient clinics

Dr D B JAMES (Marlow, Bucks) writes: Waits of several months for outpatient appointments are quite common and contribute to patient anxiety if not morbidity or actual mortality. One contribution which the general practitioner can make is to order such investigations in advance as are relevant so that the case is adequately "worked up" by the time the consultant sees the patient. . . . A second measure would be for greater "daring" on the part of the consultant to delegate more of the follow-up consultations to the GP. . . . The average GP is quite prepared to accept specific, even dogmatic, instruction in the case of his patient if in return he can expect that initial outpatient appointments will be made within a reasonable time.

Sickle-cell anaemia and measles

Dr A K SINHA (Tongo, Sierra Leone) writes: Measles is a killer disease in this part of the world. One would expect children with sickle-cell anaemia to be more vulnerable to measles than the non-sicklers. My observations have given me the impression that sicklers with measles are better off than non-sicklers. Sicklers remained generally much better and became apyrexial within two to three days. On the other hand, non-sicklers were miserable and very unwell with high pyrexia continuing for five to seven days, although the same treatment was given to both groups. Owing to lack of reference facilities I can only assume that lack of some form of enzyme system in sicklers might be detrimental to virus proliferation. I would be interested to know of any similar observation by readers or of work that has been done on this.

Medical terminology

Dr E H PORTER (Glasgow Institute of Radiotherapeutics) writes: Dr R C Chivers (8 November, p 346) suggests that medical terminology be reformed for the benefit of physicists. . . . But equally physicists should reform their terminology for our benefit. A high-speed electron is a beta particle (or even beta ray) sometimes and a high-speed electron at other times; and when it loses energy the result is an *x* ray or *Bremsstrahlung* according to a very complicated system of conventions. . . . Mutual intelligibility is good, but there is a proverb about pots and kettles.

Dalkon shield and complications of pregnancy

Dr H C NOTTEBART jun (A H Robins Co, Richmond, Virginia) writes: In a short report by Dr J S McCracken (20 September, p 684) entitled "Rhesus sensitisation associated with IUD in pregnancy" . . . the statement is made that "intrauterine contraceptive devices, and in particular the Dalkon shield, have been associated with a number of other complications of pregnancy." . . . The reference given for this statement was to a leading article (31 May, p 458) in which the conclusion was reached that there were several complications associated with any and all intrauterine devices. . . .

In a further short report by Mr. A K Thomas (27 September, p 747) entitled, "Septic abortion associated with a Lippes loop" it is stated that the Dalkon shield has been mainly concerned with this complication and the Food and Drug Administration suspended sales of it in the USA in June 1974." . . . The FDA did not suspend sales of the Dalkon shield: the A H Robins Company voluntarily suspended marketing it in June 1974. The authors, apparently quoting the Ad Hoc Obstetric/Gynecology Advisory Committee report of 29-30 October 1974, note that the FDA had reports on 219 septic abortions and 13 deaths associated with the Dalkon shield. Not mentioned, however, were statistics from the same report of 17 deaths associated with the Lippes loop, four with the Saf-T-Coil, and four with all other devices. Since the FDA obtained these data in the light of nationwide publicity with respect to the Dalkon shield there is at least some possibility that the data may have been biased against the Dalkon shield and in favour of those devices not subjected to such publicity. There has never been any definite evidence to prove that the Dalkon shield caused a disproportionate number of septic abortions or deaths. . . .

Trainer-teaching techniques

Dr J L KEARNS (London W14) writes: . . . I have no doubt that the techniques described by Dr C Josephs (25 October, p 224) have a place in promoting an appropriate humility in the trainer, who must persuade the more academic trainee to question basic assumptions which masquerade as facts in textbooks. Nevertheless, exclusive attention to "non-directive" teaching has diverted effort from the preparation of training material concerning management of a practice, disability as it affects the earning capacity of the patient, use of and relationships with the other "social agencies," etc, which I had not fully understood after years in general practice. . . .

Smoking and lung aging

Dr M D W LYE (Department of Geriatric Medicine, University of Manchester) writes: Cigarette smoking undeniably gives rise to pathological changes in the lung such as chronic bronchitis in many but not all individuals who are addicted to the habit. This pathological and functional change is not a manifestation of accelerated lung aging (leading article, 1 November, p 247). The fact that pulmonary function indices, such as FEV_1, decline with age faster in smokers than in non-smokers is a reflection of the fact that the functional abnormalities of chronic bronchitis and the total number of cigarettes smoked are both age related rather than age mediated. For example, airways resistance does not increase with age in the absence of lung pathology.[1] Similarly emphysema ("senile emphysema") is not a feature of aged lungs.[2] It is important to emphasise this differentiation as respiratory symptoms, and in particular dyspnoea, are commonly attributed to increasing age by patients, their relatives, and on occasion their doctors. Invariably shortness of breath in the elderly is related to some pathological condition—bronchitis, asthma, heart failure, etc—requiring active management and specific therapy.

1 Lye, M D W, *Modern Geriatrics*, 1975, **5**, 30.
2 Briscoe, W A, and Dubois, A B, *Journal of Clinical Investigation*, 1958, **37**, 1279.

Improving the NHS

Miss LYNN JAMES and six other social workers from the West Midlands write: Professor Myre Sim (18 October, p 160) surely takes the easier course when he looks back and castigates in vague and emotive terms the system from which he has chosen to opt out. Less pretentious but more difficult are the efforts of "girl social workers," nurses, psychologists, and Professor Sim's own medical colleagues to work towards professional understanding and a better and more comprehensive service for the majority of patients for whom the NHS and social services offer the only source of treatment and help.

Industrial action

Dr J STUART BROWN (Aylesford, Kent) writes: The junior doctors have a reasonable cause for grievance—the consultants have a much stronger case—but patients are suffering and will certainly die as a result of industrial action by *any* members of the Health Service, be they porters, nurses, or doctors. We have no quarrel with our patients, and refusing to treat them when they are ill is no different from terrorists endangering innocent lives believing their cause is a just one. . . . Please—all of us in the Health Service—don't forget the patient.

Dr H BARBARA WOODHOUSE (Stanmore, Middlesex) writes: Doctors taking industrial action to safeguard not only their financial position but also their future prospects call for our sympathy and for all the support we can give. Not one of us with any sense of vocation can willingly cause needless suffering to his or her patients through restricted service. . . . The present impasse represents a threat to the freedom not only of doctors, but also of the general public. . . . Our fight to maintain our freedom becomes, therefore, a campaign on behalf of the nation as a whole. . . .